FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004077

Facility Name: AMBASSADOR NURSING CTR

Address: 4900 N. BERNARD (Number) CHICAGO (City) 60625 (Zip Code)

County: COOK

Telephone Number: (773) 583-7130 **Fax #** (773) 583-3929

IDPA ID Number: 362900425001

Date of Initial License for Current Owners: 05/15/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) MARVIN FOX, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	190	Skilled (SNF)	190	69,350	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,592	2,529	6,625	31,746	8
9	SNF/PED					9
10	ICF	23,876	772	366	25,014	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,468	3,301	6,991	56,760	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.85%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/15/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 36 and days of care provided 6121

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	331,502	26,465	12,798	370,765		370,765	12,260	383,025			1
2	Food Purchase		247,824		247,824	(38,610)	209,214	(144)	209,070			2
3	Housekeeping	187,621	30,277		217,898		217,898		217,898			3
4	Laundry	69,768	21,959		91,727		91,727		91,727			4
5	Heat and Other Utilities			152,409	152,409		152,409	1,321	153,730			5
6	Maintenance	42,742		98,941	141,683		141,683	(6,574)	135,109			6
7	Other (specify):*							6,001	6,001			7
8	**TOTAL General Services**	631,633	326,525	264,148	1,222,306	(38,610)	1,183,696	12,864	1,196,560			8
	B. Health Care and Programs											
9	Medical Director			20,100	20,100		20,100		20,100			9
10	Nursing and Medical Records	1,530,738	111,507	440,924	2,083,169		2,083,169	(7,512)	2,075,657			10
10a	Therapy	101,389		7,042	108,431		108,431	(577)	107,854			10a
11	Activities	95,065	7,523	4,174	106,762		106,762		106,762			11
12	Social Services	47,118		2,336	49,454		49,454		49,454			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,149	4,149			15
16	**TOTAL Health Care and Programs**	1,774,310	119,030	474,576	2,367,916		2,367,916	(3,940)	2,363,976			16
	C. General Administration											
17	Administrative	247,036		546,865	793,901		793,901	(335,899)	458,002			17
18	Directors Fees											18
19	Professional Services			94,911	94,911	(3,355)	91,556	2,411	93,967			19
20	Dues, Fees, Subscriptions & Promotions			104,302	104,302		104,302	(51,090)	53,212			20
21	Clerical & General Office Expenses	187,094	44,546	185,931	417,571		417,571	(25,628)	391,943			21
22	Employee Benefits & Payroll Taxes			469,084	469,084	38,610	507,694		507,694			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,901	3,901		3,901	(484)	3,417			24
25	Other Admin. Staff Transportation			177	177		177		177			25
26	Insurance-Prop.Liab.Malpractice			133,061	133,061		133,061	20	133,081			26
27	Other (specify):*							41,917	41,917			27
28	**TOTAL General Administration**	434,130	44,546	1,538,232	2,016,908	35,255	2,052,163	(368,753)	1,683,410			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,840,073	490,101	2,276,956	5,607,130	(3,355)	5,603,775	(359,829)	5,243,946			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number AMBASSADOR NURSING CTR #0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			106,072	106,072		106,072	65,968	172,040			30
31	Amortization of Pre-Op. & Org.			38,218	38,218		38,218	4,408	42,626			31
32	Interest			89,064	89,064		89,064	132,164	221,228			32
33	Real Estate Taxes			242,047	242,047	3,355	245,402		245,402			33
34	Rent-Facility & Grounds			583,356	583,356		583,356	(570,616)	12,740			34
35	Rent-Equipment & Vehicles			18,096	18,096		18,096	1,213	19,309			35
36	Other (specify):*			7,630	7,630		7,630	(3,758)	3,872			36
37	**TOTAL Ownership**			1,084,483	1,084,483	3,355	1,087,838	(370,621)	717,217			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	323	272,011	657,089	929,423		929,423	(77,620)	851,803			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):*	33,519		23,803	57,322		57,322	(57,322)				43
44	**TOTAL Special Cost Centers**	33,842	272,011	784,917	1,090,770		1,090,770	(134,942)	955,828			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,873,915	762,112	4,146,356	7,782,383		7,782,383	(865,392)	6,916,991			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,826)	30		9
10	Interest and Other Investment Income	(1,794)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(144)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(901)	24		19
20	Contributions	(7,415)	21		20
21	Owner or Key-Man Insurance	(10,268)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,070)	21		24
25	Fund Raising, Advertising and Promotional	(50,354)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,492)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,427)	20		28
29	Other-Attach Schedule	(153,530)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (296,221)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(569,171)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (569,171)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (865,392)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

AMBASSADOR NURSING CTR

ID# 0004077

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank charges (Bldg co.)	$ (8,856)	21	1
2	Marketing salary	(33,469)	43	2
3	Marketing consultant	(23,803)	43	3
4	Bank charges	(16,979)	21	4
5	Illinois Council COPE	(3,810)	20	5
6	Marketing salary bonus	(50)	43	6
7	Capitalized R&M	(6,854)	06	7
8	Part B coinsurance-bad debt	(57,955)	21	8
9	Accounting fees (Bldg co.)	(1,754)	19	9
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				1,602	790		110			9,758		12,260	1
2	Food Purchase	(144)											(144)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,059			262						1,321	5
6	Maintenance	(6,854)		42	1,484		175	(1,421)					(6,574)	6
7	Other (specify):*				3,816	16		2,169					6,001	7
8	**TOTAL General Services**	(6,998)		1,101	6,902	806	437	858			9,758		12,864	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			16,492			6,706				(30,710)		(7,512)	10
10a	Therapy								(370)	(207)			(577)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			2,708			1,441						4,149	15
16	**TOTAL Health Care and Programs**			19,200			8,147		(370)	(207)	(30,710)		(3,940)	16
	C. General Administration													
17	Administrative			88,817	(317,917)	(48,279)	54,113	(112,633)					(335,899)	17
18	Directors Fees													18
19	Professional Services	(1,754)	1,754	5,340		(7,722)	4,793						2,411	19
20	Fees, Subscriptions & Promotions	(58,591)		5,249		42	2,210						(51,090)	20
21	Clerical & General Office Expenses	(164,035)	8,896	75,031		11,780	42,700						(25,628)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(901)		150			267						(484)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			18			2						20	26
27	Other (specify):*			22,247		385	19,285						41,917	27
28	**TOTAL General Administration**	(225,281)	10,650	196,852	(317,917)	(43,794)	123,370	(112,633)					(368,753)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(232,279)	10,650	217,153	(311,015)	(42,988)	131,954	(111,775)	(370)	(207)	(20,952)		(359,829)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,826)	57,148	11,307		1,899	440						65,968	30
31	Amortization of Pre-Op. & Org.		4,408										4,408	31
32	Interest	(1,794)	129,727	2,780		1,456	(5)						132,164	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(583,356)	8,648			4,092						(570,616)	34
35	Rent-Equipment & Vehicles				903		310						1,213	35
36	Other (specify):*					(3,758)							(3,758)	36
37	TOTAL Ownership	(6,620)	(392,073)	22,735	903	(403)	4,837						(370,621)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(26,384)	(35,385)	(15,851)		(77,620)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(57,322)											(57,322)	43
44	TOTAL Special Cost Centers	(57,322)							(26,384)	(35,385)	(15,851)		(134,942)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(296,221)	(381,423)	239,888	(310,112)	(43,391)	136,791	(111,775)	(26,754)	(35,592)	(36,803)		(865,392)	45

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest expense-mortgage	$	Ambassador Building Partnership		$ 129,727	$ 129,727	1
2	V	19	Accounting fees		Ambassador Building Partnership		1,754	1,754	2
3	V	31	Amortization expense		Ambassador Building Partnership		4,408	4,408	3
4	V	30	Depreciation expense		Ambassador Building Partnership		57,148	57,148	4
5	V	21	Bank charges		Ambassador Building Partnership		8,856	8,856	5
6	V	21	Office expense		Ambassador Building Partnership		40	40	6
7	V	34	Rent income	583,356	Ambassador Building Partnership			(583,356)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 583,356			$ 201,933	$ * (381,423)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	QUALITY CARE MANAGEMENT	100.00%	$ 1,059	$ 1,059	15
16	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	42	42	16
17	V	10	SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	15,110	15,110	17
18	V	10	NURS SAL-M. CLARKE		QUALITY CARE MANAGEMENT	100.00%	1,382	1,382	18
19	V	15	EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	2,708	2,708	19
20	V	17	ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	21,661	21,661	20
21	V	17	ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%	3,676	3,676	21
22	V	17	ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	12,108	12,108	22
23	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	31,853	31,853	23
24	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	4,629	4,629	24
25	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	1,905	1,905	25
26	V	17	ADMIN. SAL. - STEVE VAN CAMP		QUALITY CARE MANAGEMENT	100.00%			26
27	V	17	ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	12,985	12,985	27
28	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	5,340	5,340	28
29	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	5,249	5,249	29
30	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	67,111	67,111	30
31	V	21	ACCTG SAL-B. LARIMORE		QUALITY CARE MANAGEMENT	100.00%	5,308	5,308	31
32	V	21	OFFICE SAL-M. CLOCH		QUALITY CARE MANAGEMENT	100.00%	2,612	2,612	32
33	V	24	EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	150	150	33
34	V	26	INSURANCE		QUALITY CARE MANAGEMENT	100.00%	18	18	34
35	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	22,247	22,247	35
36	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	11,307	11,307	36
37	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	2,780	2,780	37
38	V	34	OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	8,648	8,648	38
39	Total			$			$ 239,888	$ * 239,888	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL	$	QUALITY CARE MANAGEMENT	100.00%	$ 903	$ 903	15
16	V								16
17	V	17	CORPORATE ALLOCATION	317,917	QUALITY CARE MANAGEMENT	100.00%		(317,917)	17
18	V								18
19	V	6	REPAIRS AND MAINT.	13,064	QUALITY CARE MANAGEMENT	100.00%	14,548	1,484	19
20	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%	2,388	2,388	20
21	V								21
22	V	1	DIETICIAN SALARIES	7,095	QUALITY CARE MANAGEMENT	100.00%	8,697	1,602	22
23	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	1,428	1,428	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 338,076			$ 27,964	$ * (310,112)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN SAL-NON-OWNER	$	QUALITY CARE MANAGEMENT	100.00%	$ 1,087	$ 1,087	15
16	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	3,475	3,475	16
17	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	2,462	2,462	17
18	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	1,013	1,013	18
19	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	278	278	19
20	V	17	MGNT FEES-DIRECT ALLOC		QUALITY CARE MANAGEMENT	100.00%	112,632	112,632	20
21	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	42	42	21
22	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	11,780	11,780	22
23	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	385	385	23
24	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	1,899	1,899	24
25	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	1,456	1,456	25
26	V	36	GAIN ON SALE OF ASSETS		QUALITY CARE MANAGEMENT	100.00%	(3,758)	(3,758)	26
27	V								27
28	V	17	CORPORATE ALLOCATION	168,948	QUALITY CARE MANAGEMENT	100.00%		(168,948)	28
29	V	19	COMPUTER SERVICES	8,000	QUALITY CARE MANAGEMENT	100.00%		(8,000)	29
30	V								30
31	V	1	DIETICIAN SALARIES		QUALITY CARE MANAGEMENT	100.00%	790	790	31
32	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	16	16	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 176,948			$ 133,557	$ * (43,391)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 262	$ 262	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	175	175	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	890	890	17
18	V	10	SAL-NURSING-M. CLARKE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,816	5,816	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,441	1,441	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	13,111	13,111	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,368	10,368	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,472	7,472	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,770	8,770	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,448	6,448	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,944	7,944	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,793	4,793	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,210	2,210	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	40,220	40,220	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,480	2,480	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	267	267	32
33	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2	2	33
34	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	19,285	19,285	34
35	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	440	440	35
36	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	(5)	(5)	36
37	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,092	4,092	37
38	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	310	310	38
39	Total			$			$ 136,791	$ * 136,791	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	CORP ALLOC/MGMT FEE	112,633	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	$ (112,633)	15
16	V								16
17	V	6	REPAIRS AND MAINT.	8,112	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,691	(1,421)	17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,488	1,488	18
19	V								19
20	V	1	DIETICIAN SALARIES	2,955	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,065	110	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	681	681	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 123,700			$ 11,925	$ * (111,775)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 5,535	AT&R II, LLC	100.00%	$ 5,165	$ (370)	15
16	V	39	ANCILLARY REHAB	394,968	AT&R II, LLC	100.00%	368,584	(26,384)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 400,503			$ 373,749	$ * (26,754)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 1,508	Advanced Therapy and Rehab, LLC	100.00%	$ 1,301	$ (207)	15
16	V	39	ANCILLARY REHAB	257,720	Advanced Therapy and Rehab, LLC	100.00%	222,335	(35,385)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 259,228			$ 223,636	$ * (35,592)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 26,396	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 10,545	$ (15,851)	15
16	V	10	MEDICAL SUPPLIES	34,892	QUALITY CARE MEDICAL SUPPLY	100.00%	4,182	(30,710)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	9,758	9,758	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 61,288			$ 24,485	$ * (36,803)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Meisels	Admin. Consultant	Administrative	50.00%	See attached	7.5	13.60%	Facility salary	$ 97,266	17-1	1
2	Brucha Teitelbaum	Relative	Administrative	0	See attached	1.04	2.60%	Alloc. Salary	7,091	17-7	2
3	Joseph Meisels	Relative	Administrative	0	See attached	4.14	8.28%	Alloc. Salary	2,918	17-7	3
4	David Meisels	Exec. Administrator	Administrative	0	See attached	7.5	13.60%	Mgmt fees	60,000	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 167,275		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	258,551	8	$ 7,246	$	37,785	$ 1,059	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	258,551	8	290		37,785	42	2
3	10	SAL-NURSING	PATIENT DAYS	258,551	8	103,396	103,396	37,785	15,110	3
4	10	NURS SAL-M. CLARKE	PATIENT DAYS	258,551	8	9,458	9,458	37,785	1,382	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	258,551	8	18,527		37,785	2,708	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	258,551	8	148,217	148,217	37,785	21,661	6
7	17	ADMIN. SAL.- A. SALTZMAN	DIRECT/PATIENT DAYS		6	22,590	22,590		3,676	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	258,551	8	82,852	82,852	37,785	12,108	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	258,551	8	217,962	217,962	37,785	31,853	9
10	17	ADMIN. SAL. - B. TEITELBAUM	DIRECT/PATIENT DAYS		5	22,566	22,566		4,629	10
11	17	ADMIN. SAL - J. MEISELS	DIRECT/PATIENT DAYS		5	9,284	9,284		1,905	11
12	17	ADMIN. SAL. - STEVE VAN CA	DIRECT/PATIENT DAYS		3	10,508	10,508			12
13	17	ADMIN. SAL. - MIKE FILIPPO	PATIENT DAYS	258,551	8	88,849	88,849	37,785	12,985	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	258,551	8	36,541		37,785	5,340	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	258,551	8	35,917		37,785	5,249	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	258,551	8	459,219	364,702	37,785	67,111	16
17	21	ACCTG SAL-B. LARIMORE	DIRECT/PATIENT DAYS		7	35,710	35,710		5,308	17
18	21	OFFICE SAL-M. CLOCH	PATIENT DAYS	258,551	8	17,876	17,876	37,785	2,612	18
19	24	EDUCATION & SEMINAR	PATIENT DAYS	258,551	8	1,028		37,785	150	19
20	26	INSURANCE	PATIENT DAYS	258,551	8	121		37,785	18	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	258,551	8	152,231		37,785	22,247	21
22	30	DEPRECIATION	PATIENT DAYS	258,551	8	77,371		37,785	11,307	22
23	32	INTEREST	PATIENT DAYS	258,551	8	19,022		37,785	2,780	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	258,551	8	59,175		37,785	8,648	24
25	TOTALS					$ 1,635,956	$ 1,133,970		$ 239,888	25

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	258,551	8	$ 6,176	$	37,785	$ 903	1
2										2
3										3
4										4
5	6	REPAIRS AND MAINT.	PAINTING REVENUE	24,700	4	27,506	27,506	13,064	14,548	5
6	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	24,700	4	4,515		13,064	2,388	6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN REVENUE	34,652	8	42,478	42,478	7,095	8,697	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	34,652	8	6,973		7,095	1,428	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 87,648	$ 69,984		$ 27,964	25

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	89,917	5	$ 5,150	$ 5,150	18,975	$ 1,087	1
2	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	89,917	5	16,467	16,467	18,975	3,475	2
3	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	89,917	5	11,667	11,667	18,975	2,462	3
4	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	89,917	5	4,800	4,800	18,975	1,013	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	89,917	5	1,316		18,975	278	5
6	17	MGNT FEES-DIRECT ALLOC	DIRECT ALLOCATION		5	541,973			112,632	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	89,917	5	200		18,975	42	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	89,917	5	55,820		18,975	11,780	8
9	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	89,917	5	1,825		18,975	385	9
10	30	DEPRECIATION	PATIENT DAYS	89,917	5	8,999		18,975	1,899	10
11	32	INTEREST	PATIENT DAYS	89,917	5	6,900		18,975	1,456	11
12	36	GAIN ON SALE OF ASSETS	PATIENT DAYS	89,917	5	(17,809)		18,975	(3,758)	12
13										13
14										14
15										15
16										16
17	1	DIETICIAN SALARIES	DIETICIAN REVENUE	4,053	3	3,527	3,527	908	790	17
18	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	4,053	3	71		908	16	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 640,906	$ 41,611		$ 133,557	25

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	147,139	8	$ 2,034	$	18,975	$ 262	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	147,139	8	1,354		18,975	175	2
3	10	NURSING	PATIENT DAYS	147,139	8	6,902	5,142	18,975	890	3
4	10	SAL-NURSING-M. CLARKE	PATIENT DAYS	147,139	8	45,100	45,100	18,975	5,816	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	147,139	8	11,172		18,975	1,441	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	147,139	8	101,666	101,666	18,975	13,111	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	147,139	8	80,400	80,400	18,975	10,368	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	147,139	8	57,937	57,937	18,975	7,472	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	147,139	8	68,004	68,004	18,975	8,770	9
10	17	ADMIN. SAL. - C. ROSS	DIRECT/PATIENT DAYS		4	4,050	4,050	18,975		10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	147,139	8	50,000	50,000	18,975	6,448	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	147,139	8	61,604	61,604	18,975	7,944	12
13	17	ADMIN. SAL. - J. ELOWE	AVERAGE HOURS	10	3	12,210				13
14	19	PROFESSIONAL FEES	PATIENT DAYS	147,139	8	37,170		18,975	4,793	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	147,139	8	17,139		18,975	2,210	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	147,139	8	311,878	242,119	18,975	40,220	16
17	21	SALARIES-ACCTG-B. LARIMO	DIRECT/PATIENT DAYS		7	17,000	17,000	18,975	2,480	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	147,139	8	2,070		18,975	267	18
19	26	INSURANCE	PATIENT DAYS	147,139	8	13		18,975	2	19
20	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	147,139	8	149,543		18,975	19,285	20
21	30	DEPRECIATION	PATIENT DAYS	147,139	8	3,414		18,975	440	21
22	32	INTEREST	PATIENT DAYS	147,139	8	(39)		18,975	(5)	22
23	34	OFFICE RENT-UNRELATED	PATIENT DAYS	147,139	8	31,727		18,975	4,092	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	147,139	8	2,402		18,975	310	24
25	TOTALS					$ 1,074,750	$ 733,022		$ 136,791	25

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	8,632	2	7,120	7,120	8,112	6,691	3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	8,632	2	1,583		8,112	1,488	4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	19,790	8	20,524	20,524	2,955	3,065	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	19,790	8	4,564		2,955	681	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 33,791	$ 27,644		$ 11,925	25

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AT&R II, LLC
Street Address: 8950 Gross Point Rd. #E
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						5,165	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						368,584	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 373,749	25

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Advanced Therapy and Rehab, LLC
Street Address: 8950 Gross Point Rd. #E
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						1,301	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						222,335	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 223,636	25

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Quality Care Medical Supply
Street Address: 8950 Gross Point Rd. #E
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						10,545	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						4,182	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						9,758	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 24,485	25

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Boatman's Mortgage		X	Mortgage	$14,446		$ 1,970,600	$ 1,506,037	10/1/17	8.50%	$ 129,727	1
2	DVI		X	Line of credit				977,161			9,180	2
3	Medical Staffing Network		X								4,719	3
4	Continental		X	Mortgage				443,782			23,648	4
5												5
	Working Capital											
6	Corus Bank		X	Line of credit	Interest only		1,000,000			Prime=1/2	45,656	6
7	Hill Rom		X	Equipment purchase	$785		8,927		05/01	10.00%	96	7
8	YM Realty		X				100,000			8.00%	5,765	8
9	TOTAL Facility Related				$15,231		$ 3,079,527	$ 2,926,980			$ 218,791	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Interest income										(1,794)	11
12	Quality Care Management	X		Allocation							4,236	12
13	Boulevard Management	X		Allocation							(5)	13
14	TOTAL Non-Facility Related						$	$			$ 2,437	14
15	TOTALS (line 9+line14)						$ 3,079,527	$ 2,926,980			$ 221,228	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	215,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	225,047	2
3. Under or (over) accrual (line 2 minus line 1).	$	10,047	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	232,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	3,355	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 13,883 For 19 94-95 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	245,402	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	231,447	8
	1997	205,799	9
	1998	209,453	10
	1999	208,047	11
	2000	225,047	12

Calculation of accrual = 2000 actual $225,047 x 1.03 = $232,000

The real estate tax refund applies to years not used in calculating rates.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBASSADOR NURSING CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0004077

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-418-021	Long term care property	$ 19,858.15	$ 19,858.15
2.	13-11-418-022	Long term care property	$ 72,986.10	$ 72,986.10
3.	13-11-418-026	Long term care property	$ 92,790.05	$ 92,790.05
4.	13-11-418-028	Long term care property	$ 35,843.65	$ 35,843.65
5.	13-11-418-033	Long term care property	$ 3,568.77	$ 3,568.77
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 225,046.72	$ 225,046.72

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,497 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 176,304
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 42,626
4. Dates Incurred: _____

Nature of Costs: Mortgage costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1977	$ 127,394	1
2					2
3	TOTALS			$ 127,394	3

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1977	$ 1,714,426	$ 57,148	35	$ 57,148	$	$ 1,400,119	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	3,109		20	-		3,109	9
10	Various			1981	7,984		20	-		7,984	10
11	Various			1983	820		20	-		820	11
12	Various			1984	11,000		20	-		11,000	12
13	Various			1986	44,252		20	2,329	2,329	35,268	13
14	Various			1987	5,800		20	290	290	4,205	14
15	Various			1988	1,825		20	58	58	773	15
16	Various			1990	48,352		20	1,708	1,708	19,243	16
17	Various			1991	1,571		20	79	79	810	17
18	Various			1992	8,653		20	432	432	4,066	18
19	Various			1993	55,217		20	2,761	2,761	28,170	19
20	Various			1994	8,007		20	401	401	2,730	20
21	Various			1995	35,063		20	1,753	1,753	11,125	21
22	Various			1996	120,434		20	6,022	6,022	33,597	22
23	Various			1997	37,040		20	1,853	1,853	8,170	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			18,186			(18,186)		69
70	TOTAL (lines 4 thru 69)		$ 2,103,553	$ 75,334		$ 74,834	$ (500)	$ 1,571,189	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,103,553	$ 75,334		$ 74,834	$ (500)	$ 1,571,189	1
2	PIPES	1998	1,100		20	55	55	220	2
3	FIRE DAMPERS	1998	21,000		20	1,050	1,050	4,113	3
4	THERMO TECH	1998	1,097		20	55	55	215	4
5	ROOF TOP EXHAUST R&M	1998	2,562		20	128	128	501	5
6	Z.WALLACH	1998	1,968		20	98	98	368	6
7	WIRING	1998	1,644		20	82	82	308	7
8	WALLPAPER	1998	3,140		20	157	157	536	8
9	PUMP	1998	2,099		20	105	105	359	9
10	ELEVATOR DOOR	1998	2,000		20	100	100	342	10
11	THER ROOM WINDOW	1998	900		20	45	45	146	11
12	THERAPY RM CONSTRUC.	1998	6,800		20	340	340	993	12
13	ROOF REPLACEMENT	1998	47,000		20	2,350	2,350	7,246	13
14	HOT WTR REPAIRS	1998	3,917		20	196	196	604	14
15	PLUMBING INSTALL	1998	2,600		20	130	130	401	15
16	CARPET INSTALL	1998	4,856		20	243	243	749	16
17	THERAPY RM CONSTRUCT	1998			20				17
18	SECURITY CAMERA	1998	7,170		20	359	359	1,077	18
19	THERAPY RM CONST	1998			20	370	370	1,110	19
20	GAS LINE FOR OVENS	1998	1,574		20	79	79	237	20
21	ELEC WIRING	1998	685		20	34	34	102	21
22	MASTER KEY SYSTEM	1998	1,280		20	64	64	192	22
23	NURSE CALL SYSTEM	1998	576		20	29	29	87	23
24	CRANK HANDLES	1998	765		20	38	38	114	24
25	SPRINKLER SYSTEM	1998	688		20	34	34	102	25
26	SPRINKLER SYSTEM	1998	1,175		20	59	59	177	26
27	PAINTING & DECORATIN	1998	9,169		20	458	458	1,374	27
28	LOCK	1998	1,909		20	95	95	285	28
29	FIRE ALARM WORK	1999	1,825		20	91	91	273	29
30	FENCE	1999	580		20	29	29	87	30
31	DOOR DETECTOR	1999	1,975		20	99	99	297	31
32	FIRE PROOFING	1999	3,200		20	160	160	480	32
33	HEATING WORK	1999	2,117		20	106	106	318	33
34	TOTAL (lines 1 thru 33)		$ 2,240,924	$ 75,334		$ 82,072	$ 6,738	$ 1,594,602	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,240,924	$ 75,334		$ 82,072	$ 6,738	$ 1,594,602	1
2	ELEV WORK	1999	1,929		20	96	96	280	2
3	FIRE DOOR	1999	1,120		20	56	56	154	3
4	EXHAUST FAN PARTS	1999	2,562		20	128	128	341	4
5	OVERHEAD DOOR	1999	4,160		20	208	208	537	5
6	VACUUM BRKRS/KITCHEN	1999	864		20	43	43	111	6
7	VACUUM BRKRS/LDRYRM	1999	777		20	39	39	101	7
8	SINK	1999	702		20	35	35	90	8
9	FLOORING	1999	1,155		20	58	58	145	9
10	INSTALL SINK	1999	850		20	43	43	108	10
11	EX FANS & MOTORS	1999	1,817		20	91	91	228	11
12	HOT WATER VALVE	1999	1,964		20	98	98	245	12
13	ELEV FLOORING	1999	1,161		20	58	58	145	13
14	SHED	1999	2,847		20	142	142	355	14
15	WIRING	1999	1,225		20	61	61	158	15
16	GATES	1999	1,056		20	53	53	128	16
17	WIRING	1999	1,741		20	87	87	210	17
18	FIRE DOORS	1999	2,702		20	135	135	315	18
19	INST HANDRAILS	1999	1,600		20	80	80	187	19
20	HANDRAILS	1999	3,226		20	161	161	376	20
21	HANDRAILS	1999	8,652		20	433	433	1,010	21
22	WALLPAPER	1999	5,943		20	297	297	693	22
23	CEILING TILE	1999	1,706		20	85	85	198	23
24	HOT WATER PUMP	1999	1,111		20	56	56	126	24
25	PUMP & TANK SYSTEM	1999	1,562		20	78	78	176	25
26	INST HANDRAILS	1999	520		20	26	26	56	26
27	FLOORING	1999	21,896		20	1,095	1,095	2,373	27
28	ELECTRIC SERV	1999	800		20	40	40	90	28
29	DOUBLE DOORS	1999	1,275		20	64	64	144	29
30	DOOR CHECKS	1999	1,584		20	79	79	184	30
31	NURSING CALL SYS	1999	598		20	30	30	73	31
32	BOILER REHAB	1999	1,605		20	80	80	193	32
33	DIESEL REHAB	1999	1,600		20	80	80	200	33
34	TOTAL (lines 1 thru 33)		$ 2,323,234	$ 75,334		$ 86,187	$ 10,853	$ 1,604,332	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,323,234	$ 75,334		$ 86,187	$ 10,853	$ 1,604,332	1
2	5-FANS	1999	1,675		20	84	84	217	2
3	ELECTCL BOX & WIRE	1999	1,808		20	90	90	203	3
4	SPRINKLER	1999	1,352		20	68	68	147	4
5	DRAPERIES	1999	27,981		20	1,399	1,399	2,919	5
6	PAINTING & DECORAT	1999	14,612		20	731	731	1,523	6
7	FIRE SYSTEM HORN	2000	700		20	224	224	364	7
8	SMOKE DETECTORS	2000	1,224		20	392	392	637	8
9	FENCE	2000	2,644		20	251	251	383	9
10	RANDEL ELECT	2000	16,761		20	430	430	770	10
11	FENCE	2000	2,613		20	248	248	379	11
12	WIRING	2000	23,500		20	603	603	1,080	12
13	SMOKE DETECTORS	2000	1,817		20	47	47	84	13
14	REPAIR SUN PORCH	2000	2,500		20	64	64	88	14
15	CHILLER REPAIR	2000	3,903		20	100	100	138	15
16	A/C	2000	900		20	23	23	32	16
17	ROOM SIGNS	2000	1,695		20	43	43	70	17
18	LAWN FAUCETS	2000	1,557		20	40	40	52	18
19	CITY SCREEN	2000	1,068		20	27	27	35	19
20	PLUMBING	2000	1,196		20	31	31	37	20
21	WATER LINE	2000	809		20	21	21	25	21
22	URINALS	2000	612		20	16	16	21	22
23	RANDEL	2000	1,030		20	26	26	27	23
24	FENCE	2000	988		20	94	94	144	24
25	WALK-IN FREEZER	2000	521		20	26	26	46	25
26	FIREPROOF WALLS	2000	550		20	28	28	51	26
27	FAN MOTOR	2000	1,276		20	64	64	96	27
28	TOILET	2000	698		20	35	35	67	28
29	FIRE ALARM	2000	528		20	26	26	35	29
30	LOCKS	2000	550		20	28	28	35	30
31	PLUMBING	2000	1,206		20	60	60	100	31
32	PLUMBING	2000	1,101		20	55	55	92	32
33	PLUMBING	2000	932		20	47	47	82	33
34	TOTAL (lines 1 thru 33)		$ 2,443,541	$ 75,334		$ 91,608	$ 16,274	$ 1,614,311	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,443,541	$ 75,334		$ 91,608	$ 16,274	$ 1,614,311	1
2	PAINTING & DECOR	2000	993		20	50	50	75	2
3	GFI RECEPTACLE	2000	657		20	33	33	41	3
4	SPRINKLER	2000	713		20	36	36	42	4
5	DOORS	2000	965		20	48	48	80	5
6	PLUMBING	2000	1,191		20	60	60	70	6
7	PLUMBING	2000	807		20	40	40	50	7
8	SPRINKLERS	2000	535		20	27	27	43	8
9	ELECTRICAL	2000	519		20	26	26	35	9
10	FAUCETS	2000	1,101		20	55	55	73	10
11	PLUMBING	2000	847		20	42	42	60	11
12	SPRINKLER	2000	1,225		20	61	61	92	12
13	FAN COIL	2000	953		20	48	48	72	13
14	TOWER FAN	2000	1,016		20	51	51	76	14
15	PLUMBING	2000	503		20	25	25	29	15
16	DOORS	2000	670		20	34	34	42	16
17	FIRE STOPPERS	2001	3,639		20	89	89	89	17
18	INSTALL FIRESTOPPING	2001	16,950		20	344	344	344	18
19	INSTALL SPEAKERS	2001	850		20	17	17	17	19
20	INSTALL FIRESTOPPING	2001	21,850		20	443	443	443	20
21	SLOT SIGNS	2001	1,968		20	35	35	35	21
22	FURNISH & INSTALL LT	2001	775		20	14	14	14	22
23	FIRE STOPPERS	2001	1,819		20	29	29	29	23
24	BUILDING FIREWALL	2001	1,525		20	31	31	31	24
25	REPLACE COOLING TOWE	2001	15,650		20	251	251	251	25
26	CONCRETE FRONT ENTNC	2001	6,500		20	35	35	35	26
27	INSTALL EXT EXIT SGN	2001	2,019		20	11	11	11	27
28	ANTENNA W/SIGNALLING	2001	2,141		20	11	11	11	28
29	INSTALL MOTOR PUMP	2001	1,100		20	4	4	4	29
30	SECURITY & ALRM SYST	2001	1,011		20	3	3	3	30
31	REPAIR FIRE ALARM	2001	1,469		20	2	2	2	31
32	BOILER REPAIR	2001	1,853		20	42	42	42	32
33	INSTALL MOTOR PUMP	2001	1,324		20	1	1	1	33
34	TOTAL (lines 1 thru 33)		$ 2,538,679	$ 75,334		$ 93,606	$ 18,272	$ 1,616,553	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,538,679	$ 75,334		$ 93,606	$ 18,272	$ 1,616,553	1
2	FURNISH & INSTALL BL	2001	620		20	31	31	31	2
3	CUBICLE CURTAIN	2001	2,296		20	115	115	115	3
4	FIRESTOPPER	2001	565		20	28	28	28	4
5	MOTOR WORK	2001	824		20	41	41	41	5
6	FIRE PUMP	2001	664		20	33	33	33	6
7	CUBICLE CURTAIN	2001	721		20	36	36	36	7
8	CONDENSOR CHILLER	2001	1,011		20	51	51	51	8
9	LAMPS	2001	654		20	33	33	33	9
10	CARPET SEAM WORK	2001	525		20	26	26	26	10
11	HOT WATER VALVE SEAL	2001	517		20	26	26	26	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,547,076	$ 75,334		$ 94,026	$ 18,692	$ 1,616,973	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,547,076	$ 75,334		$ 94,026	$ 18,692	$ 1,616,973	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,547,076	$ 75,334		$ 94,026	$ 18,692	$ 1,616,973	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,547,076	$ 75,334		$ 94,026	$ 18,692	$ 1,616,973	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,547,076	$ 75,334		$ 94,026	$ 18,692	$ 1,616,973	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,547,076	$ 75,334		$ 94,026	$ 18,692	$ 1,616,973	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,547,076	$ 75,334		$ 94,026	$ 18,692	$ 1,616,973	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 546,567	$ 101,092	$ 75,064	$ (26,028)	10	$ 258,049	71
72	Current Year Purchases	28,660	440	2,950	2,510	10	2,950	72
73	Fully Depreciated Assets	450,728				10	450,728	73
74								74
75	TOTALS	$ 1,025,955	$ 101,532	$ 78,014	$ (23,518)		$ 711,727	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,700,425	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 176,866	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 172,040	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,826)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,328,700	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Quality Care Management Allocation				8,648			5
6	Boulevard Healthcare Management Allocation				4,092			6
7	TOTAL				$ 12,740 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 19,309 Description: See attached schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 14,248	$		$ 14,248	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,687			3,687	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			636,490			636,490	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			2,664	136,437		139,101	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 01		323					323	12
13	Other (specify):						135,574		135,574	13
14	TOTAL			$ 323		$ 657,089	$ 272,011		$ 929,423	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (11,803)	$ (9,330)	1
2	Cash-Patient Deposits	58,673	58,673	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,889,046	1,889,046	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,853	61,853	6
7	Other Prepaid Expenses	72,702	72,702	7
8	Accounts Receivable (owners or related parties)	1,563	34,281	8
9	Other(specify): See supplemental schedule	268,418	536,836	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,340,452	$ 2,644,061	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		127,394	13
14	Buildings, at Historical Cost		1,714,426	14
15	Leasehold Improvements, at Historical Cost	664,045	675,138	15
16	Equipment, at Historical Cost	759,761	987,343	16
17	Accumulated Depreciation (book methods)	(763,086)	(2,401,806)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	13,989	13,989	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		176,304	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		(106,917)	22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 674,709	$ 1,185,871	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,015,161	$ 3,829,932	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 972,564	$ 972,566	26
27	Officer's Accounts Payable		(6,026)	27
28	Accounts Payable-Patient Deposits	58,673	58,673	28
29	Short-Term Notes Payable	443,782	443,782	29
30	Accrued Salaries Payable	73,599	73,599	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,491	14,491	31
32	Accrued Real Estate Taxes(Sch.IX-B)	232,000	232,000	32
33	Accrued Interest Payable	5,764	16,432	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	333,339	601,757	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,134,212	$ 2,407,274	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	977,161	977,161	39
40	Mortgage Payable		1,506,037	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 977,161	$ 2,483,198	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,111,373	$ 4,890,472	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (96,212)	$ (1,060,540)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,015,161	$ 3,829,932	48

*(See instructions.)

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,773	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,773	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	492,015	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(600,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (107,985)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (96,212)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,018,435	1
2	Discounts and Allowances for all Levels	(1,529,730)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,488,705	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,322,278	6
7	Oxygen	57,121	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,379,399	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	211,045	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,790	19
20	Radiology and X-Ray	570	20
21	Other Medical Services	158,212	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 390,617	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,794	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,794	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	13,883	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,883	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,274,398	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,222,306	31
32	Health Care	2,367,916	32
33	General Administration	2,016,908	33
	B. Capital Expense		
34	Ownership	1,084,483	34
	C. Ancillary Expense		
35	Special Cost Centers	986,745	35
36	Provider Participation Fee	104,025	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,782,383	40
41	**Income before Income Taxes (line 30 minus line 40)****	492,015	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 492,015	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,970	2,270	$ 66,848	$ 29.45	1
2	Assistant Director of Nursing	1,181	1,230	29,560	24.03	2
3	Registered Nurses	22,711	25,234	500,392	19.83	3
4	Licensed Practical Nurses	9,632	10,400	190,688	18.34	4
5	Nurse Aides & Orderlies	74,749	80,428	713,749	8.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	37	40	323	8.08	7
8	Rehab/Therapy Aides	8,871	9,444	101,389	10.74	8
9	Activity Director	1,848	2,070	29,550	14.28	9
10	Activity Assistants	7,924	9,043	65,515	7.24	10
11	Social Service Workers	5,771	6,273	47,118	7.51	11
12	Dietician					12
13	Food Service Supervisor	5,193	5,645	86,062	15.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,547	36,088	245,440	6.80	15
16	Dishwashers					16
17	Maintenance Workers	3,035	3,299	42,742	12.96	17
18	Housekeepers	26,648	28,487	187,621	6.59	18
19	Laundry	10,119	10,854	69,768	6.43	19
20	Administrator	3,547	3,855	101,862	26.42	20
21	Assistant Administrator	1,818	1,934	47,808	24.72	21
22	Other Administrative	3,046	3,220	97,366	30.24	22
23	Office Manager					23
24	Clerical	9,979	10,726	187,094	17.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,389	2,597	29,501	11.36	31
32	Other Health Care(specify)					32
33	Other(specify)	1,243	1,326	33,519	25.28	33
34	TOTAL (lines 1 - 33)	235,258	254,463	$ 2,873,915 *	$ 11.29	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	411	$ 12,798	01-03	35
36	Medical Director	120	20,100	09-03	36
37	Medical Records Consultant	100	4,000	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	183	7,320	10-03	39
40	Physical Therapy Consultant	82	3,701	10a-03	40
41	Occupational Therapy Consultant	74	3,341	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	93	4,174	11-03	44
45	Social Service Consultant	46	2,336	12-03	45
46	Other(specify)				46
47	Wound care consultant	18	900	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,127	$ 58,670		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	10,228	428,704	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	10,228	$ 428,704		53

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Courtney VanLonHuyzen (1/1-6/29)	Administrator	0	$ 82,016
Laurel Whitney (10/15-12/31/01)	Administrator	0	19,846
Patricia Correa (1/1-12/31/01)	Asst. Administrator	0	22,584
Soo Ahn (1/1/01-4/9/01)	Asst. Administrator	0	11,558
Bernice Simpson (1/1-12/31/01)	Weekend Administrator	0	13,766
David Meisels	Executive Administrator	50	97,266
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 247,036

B. Administrative - Other

Description	Amount
David Meisels	$ 60,000
Quality Care Management-Management fees	486,865
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 546,865

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Accounting	$ 35,117
Health Data Systems	Computer services	6,358
See attached schedule	Legal	30,273
Econocare	Purchasing consultant	1,315
Documentation Solutions	Billing services	315
JCAHO	Accreditation	2,750
Personnel Planners, Inc.	Unemployment tax consultant	950
Systematic Management Systems	Glucose billing services	3,373
Accu-Med	Computer services	2,457
GE Information Systems	Computer services	685
Konsult, Inc./RMS	Computer services	3,318
Quality Care Management	Computer svcs allocation	8,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 94,911

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,039
Unemployment Compensation Insurance	26,343
FICA Taxes	213,887
Employee Health Insurance	121,910
Employee Meals	38,610
Illinois Municipal Retirement Fund (IMRF)*	
Union pension expense	21,498
Head tax	6,760
401k expense	2,353
Employee benefits	26,215
Life insurance	79
TOTAL (agree to Schedule V, line 22, col.8)	$ 507,694

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	24,078
Health Care Worker Background Check	
(Indicate # of checks performed 13)	128
Classified advertising	9,181
Advertising and promotion	50,354
Yellow page advertising	4,427
Dues/Dues ICLTC	7,142
Licenses and fees	4,982
Quality Care/Boulevard Mgmt allocation	7,501
Less: Public Relations Expense	
Non-allowable advertising	(50,354)
Yellow page advertising	(4,427)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,212

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,000
Quality Care Management allocation	150
Boulevard Healthcare Mgmt allocation	267
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,417

**See instructions.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on LTC $10,358**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,171** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **104,025**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **38,610** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees